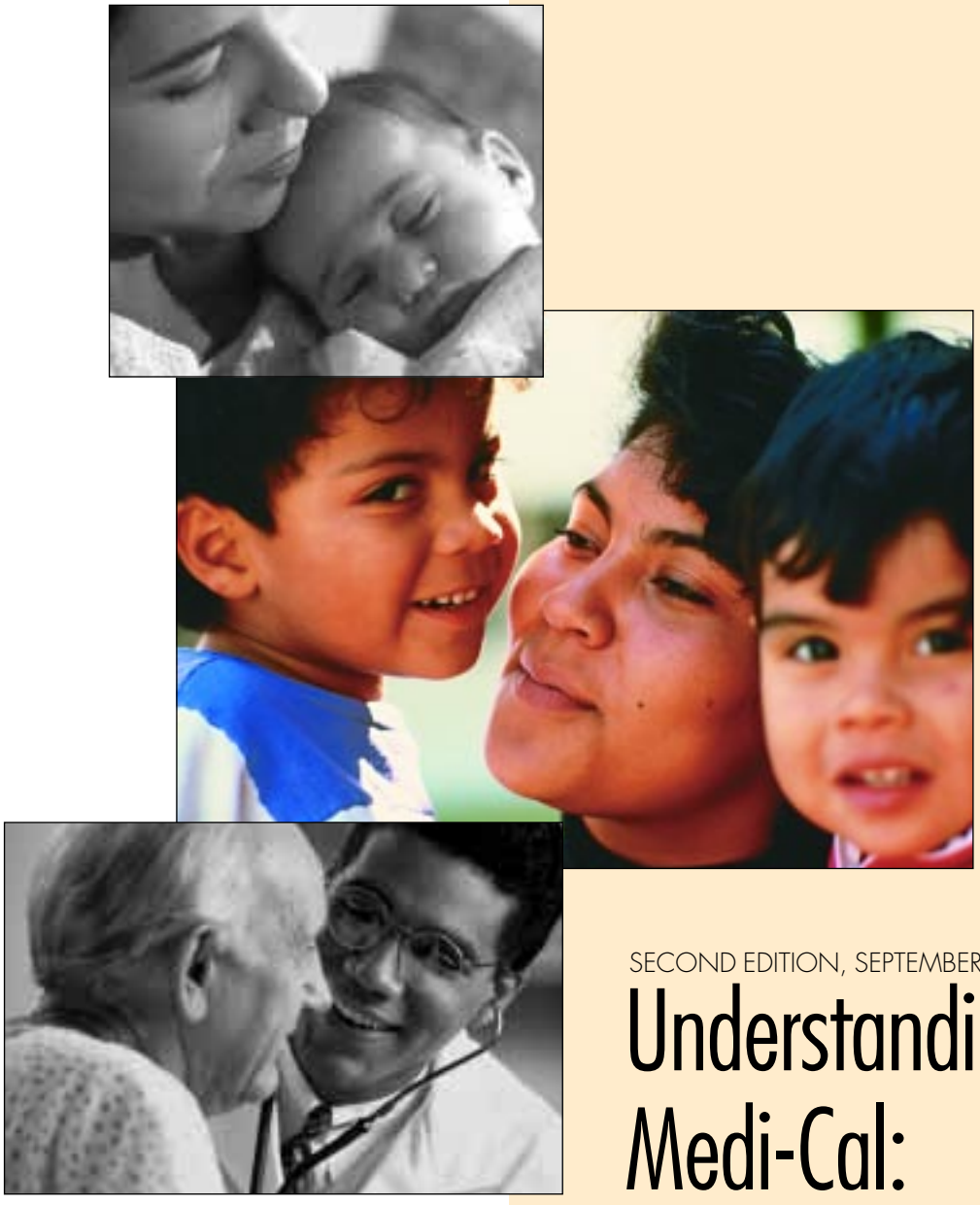
Medi-Cal *Policy Institute*



SECOND EDITION, SEPTEMBER 2001

Understanding Medi-Cal: *The Basics*

The **Medi-Cal Policy Institute,** established in 1997 by the California HealthCare Foundation, is an independent source of information on the Medi-Cal and Healthy Families programs. The Institute seeks to facilitate and enhance the development of effective policy solutions guided by the interests of the programs' consumers. The Institute conducts and commissions research, distributes information about the programs and the people they serve, highlights the programs' successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, consumer representatives, and other stakeholders who are working to create higher-quality, more efficient Medi-Cal and Healthy Families programs.

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Understanding Medi-Cal: *The Basics*

Introduction

If you were asked "Who is likely to cover your nursing home costs when you need help, provide health insurance to your neighbor, or pay for almost half of the births at your local hospital?" would you answer "Medi-Cal"? If not, you are not alone. Many people do not know the essential role Medi-Cal plays in California's health care system, nor are they aware of the wide array of services Medi-Cal provides or the diverse populations it serves.

Medi-Cal provides health care coverage and services for more than 15 percent of Californians.

Medi-Cal, California's Medicaid program:

- Provides health care coverage and services for more than 15 percent of Californians[1]
- Pays for 64 percent of nursing home care for seniors and people with disabilities[2]
- Draws more than $13 billion of federal funds into the state's health care system[3]
- Spends 5 percent of program funds on administration[4]

This primer provides answers to these key questions:

- What is Medi-Cal?
- Who is eligible for Medi-Cal?
- How do people apply and who is enrolled?
- Which services are covered by Medi-Cal?
- How is care delivered?
- How is Medi-Cal administered?
- How is the program financed and what are the program expenditures?
- What policy issues lie ahead?

Timeline of the Medi-Cal Program

1965
California establishes the Medi-Cal program.

1970
Congress expands Medicaid coverage of long-term care, particularly home health services.

1973
California establishes the Child Health and Disability Prevention (CHDP) program to provide periodic preventive health services for children.

First Medi-Cal managed care health plans are established.

1980
Medicaid Disproportionate Share Hospital (DSH) program is established.

California receives its first federal 1915(b) "Freedom of Choice" waivers.

1984
California receives its first federal 1115 "Research and Demonstration" waiver for the Senior Care Action Network (SCAN) program.

Medi-Cal is the main source of health care coverage for more than 5 million people each year.[5] Medi-Cal is the second-largest source of health care coverage in California.

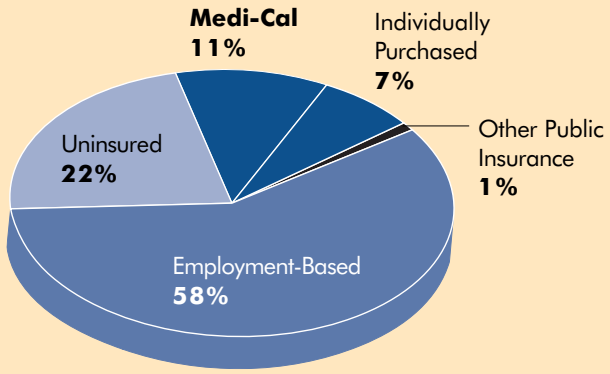
Medi-Cal also is an important source of federal funds for California's hospitals, clinics, nursing homes, and other providers, drawing more than $13 billion in federal funds into the state's health care system annually. It is estimated that more than $25 billion in federal and state funds will flow through the Medi-Cal program this year alone.[6]

Medi-Cal covers a broad range of health care services, including primary care, mental health, long-term care, and dental services. California has one of the highest percentages of total population covered by Medicaid and one of the lowest average percentages per beneficiary expenditures of any state in the country.[7]

Although some people associate Medi-Cal only with welfare, more than half of the program's funds go toward services for the elderly, disabled, and other populations.[8] For example, Medi-Cal benefits include in-home assistance for adults with disabilities, nursing home care for low-income elderly, and health care for children with physical or developmental challenges. Medi-Cal is also a program that provides important coverage for working families with low incomes. In other words, Medi-Cal directly or indirectly touches many Californians' lives, including yours.

FIGURE 1

Medi-Cal Coverage as a Percentage of Total Health Insurance Coverage, Nonelderly



Source: Gilmer, T., and R. Kronick. *New Data Shows 6.8 Million Uninsured Californians.* UCSD Department of Family and Preventive Medicine, March 22, 2001 (http://www.medicine.ucsd.edu/fpm/uninsured/table2.html).

1988
Federal Family Support Act expands Medicaid to cover certain low-income working families.

1989
Federal Omnibus Reconciliation Act expands EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), requires states to set reimbursement rates at sufficient levels, and requires Medi-Cal outstationing of enrollment.

1990
Federal Medicaid expansions (begun in 1988) are completed. Coverage for children with disabilities is broadened by Supreme Court ruling. Medi-Cal expands coverage for low-income pregnant women, children, working families, and individuals with disabilities.

1993
California Department of Health Services begins decade-long shift of many Medi-Cal beneficiaries into managed care plans.

1996
California Work Opportunity and Responsibility to Kids (CalWORKs) replaces California's prior welfare program, Aid to Families with Dependent Children (AFDC).

What Is Medi-Cal?

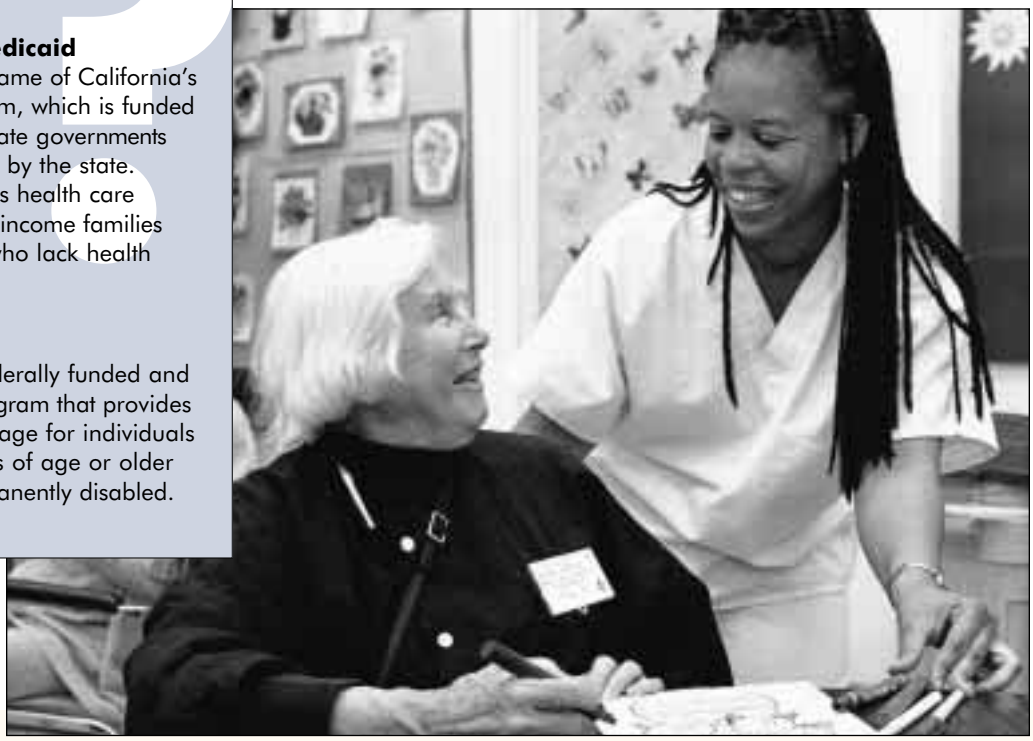
Medi-Cal—California's Medicaid program—provides health care coverage for low-income people who lack health insurance. Jointly funded by federal and state governments, Medi-Cal is the primary source of health care coverage for more than 5 million Californians.[9] Since its inception in 1965, the Medi-Cal program has grown into a complex network of public and private health care providers who serve more than 15 percent of the state's residents.[10]

The federal government created the Medicaid program in 1965 as Title XIX of the Social Security Act. Today's Medi-Cal program is different from the original program. It has expanded to address new or unmet health needs. At its core, however, the program's goal is the same: to provide medical assistance for those who need it.

Medi-Cal? Medicaid? Medicare? Which Is Which?

Medi-Cal = Medicaid
Medi-Cal is the name of California's Medicaid program, which is funded by federal and state governments and administered by the state. Medi-Cal provides health care coverage for low-income families and individuals who lack health insurance.

Medicare
Medicare is a federally funded and administered program that provides health care coverage for individuals who are 65 years of age or older or who are permanently disabled.



1997
Balanced Budget Act (BBA) establishes the State Children's Health Insurance Program (SCHIP), limits payments for DSH, and removes minimum-rate standard for nursing home care.

1998
California creates Healthy Families, raises Medi-Cal eligibility levels for children, and creates a mail-in application for children and pregnant women.

Medi-Cal mental health services are shifted completely to county-based managed care plans.

1999
Face-to-face interview requirement is eliminated for annual Medi-Cal redetermination.

Healthy Families is expanded to cover more children.

Federal waiver is approved so that Medi-Cal now covers Family PACT program.

2000
1931(b) is expanded to cover families with incomes up to 100 percent FPL.

2001
Quarterly Status Reports are eliminated for adults receiving Medi-Cal.

Continuous eligibility is implemented for children receiving Medi-Cal.

The Healthy Families Program

In 1997, Congress created the State Children's Health Insurance Program (SCHIP) to provide funding for states to expand Medicaid and/or develop new options to insure low-income children. California opted to both expand Medi-Cal and create a new health insurance program called Healthy Families.

The Healthy Families Program (HFP) began in July 1998 and was designed to provide health care coverage for children in families with incomes too high for Medi-Cal but below 200 percent FPL. Subsequently, the program has expanded the upper income limit to 250 percent FPL to cover additional children.[11]

As of July 2001, there were 460,508 children enrolled in the program.[12] In FY 2000–01, the majority of HFP enrollees (almost 70 percent) were Latino, whereas White enrollees composed 15 percent, Asian/Pacific Islanders almost 14 percent, and African Americans almost 3 percent.[13] Total HFP expenditures were almost $477 million in this same period.[14]

In 1999, an estimated 455,000 to 614,000 children were eligible for HFP but not enrolled in the program.[15] In December 2000, California submitted a request to the Centers for Medicare and Medicaid Services (formerly HCFA) to receive an 1115 waiver to allow many parents of HFP-eligible children to qualify for the program, as well as some parents of Medi-Cal–eligible children. Program officials anticipate that the waiver, if approved, will also reduce the number of eligible but not enrolled children.

Medi-Cal and the Healthy Families Program are often discussed in conjunction with each other because the programs are somewhat intertwined. There is one mail-in application for both programs, and applications are generally screened for consideration in both programs. Marketing and outreach efforts are jointly funded and administered.

Several characteristics differentiate the two programs. Healthy Families is administered by the Managed Risk Medical Insurance Board rather than the Department of Health Services. The federal government funds roughly 66 percent of Healthy Families expenditures as compared to 50 percent of Medi-Cal expenditures.[16]

Enrollees in Healthy Families pay premiums of $4 to $9 per child per month (to a maximum of $27 per family). Except in the case of preventive care, $5 copayments are required for all services.[17] While both HFP and Medi-Cal provide similar coverage, the Medi-Cal benefits package is broader and includes federally mandated EPSDT services. In addition, all services in HFP are delivered by a managed care plan whereas almost half of Medi-Cal recipients are in a fee-for-service system.

For more information, read *Medi-Cal Facts #11: Children's Medi-Cal and the Healthy Families Program* (April 2001).

Who Is Eligible for Medi-Cal?

Medi-Cal covers low-income children, their parents, and aged, blind, or disabled individuals.

Medi-Cal is a program for low-income Californians, but not everyone who is poor is eligible. Generally, Medi-Cal covers low-income children, their parents, and aged, blind, or disabled individuals. To qualify for Medi-Cal, one must meet the program's income, deprivation, and property criteria as well as institutional status, residence, and citizenship requirements. These requirements vary based on the category of eligibility. There are currently 165 categories or "aid codes" under which an individual or family may be considered eligible.[18] Most eligibility categories can be grouped into one or more of several broad classifications.

Public Assistance–Linked

- CalWORKs recipients (formerly AFDC)
- Supplemental Security Income/State Supplemental Payment (SSI/SSP) recipients
- Some families and individuals who have low incomes but do not qualify for, or do not want, CalWORKs or SSI/SSP

Section 1931(b) Only

- Families who do not receive CalWORKs but who would have been eligible if AFDC rules were still in effect
- Families who qualify for CalWORKs but want Medi-Cal coverage only
- Families whose earnings make them ineligible for cash assistance

Medically Needy and Medically Indigent

- The medically needy (MN) category includes uninsured families and individuals with incomes too high to qualify for cash assistance but who otherwise qualify for CalWORKs or SSI/SSP. (MN also covers individuals who are eligible for public assistance and opt not to receive it.)
- The medically indigent (MI) category includes low-income pregnant women, children under age 21, and some adults in long-term care who otherwise do not qualify for public assistance or as medically needy.
- Some MN and MI eligible individuals qualify only for "share of cost" Medi-Cal, in which beneficiaries must incur a certain level of medical expenses each month before Medi-Cal coverage begins.

Federal Poverty Level (FPL) Programs

- Pregnant women and infants in families with incomes at or below 200 percent of FPL
- Children ages 1 to 5 in families with incomes at or below 133 percent of FPL
- Children ages 6 to 19 in families with incomes at or below 100 percent of FPL

Other Eligibility Groups

- Transitional Medi-Cal (TMC) for families transitioning off 1931(b) due to income increases or families transitioning off CalWORKs with incomes too high for 1931(b)
- Individuals with refugee status
- Qualified low-income Medicare recipients (services not covered by Medicare)
- People in special treatment programs (for example, tuberculosis or dialysis)
- Undocumented immigrants (emergency, pregnancy-related, and certain long-term care services only)

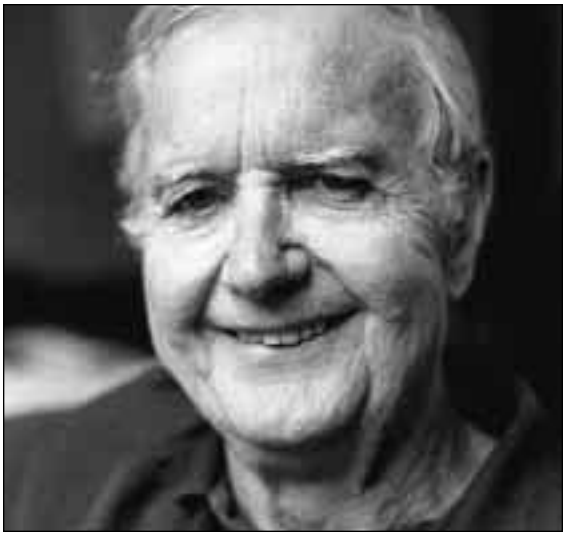
FIGURE 2

2001 Federal Poverty Guidelines
Family Size at Select Intervals of Federal Poverty Level (FPL)

Family Size	100% of FPL	133% of FPL	200% of FPL
1	$8,590	$11,425	$17,180
2	$11,610	$15,441	$23,220
3	$14,630	$19,458	$29,260
4	$17,650	$23,475	$35,300

Source: Federal Register: Vol. 66, No. 33, February 16, 2001.

For more information, read *The Guide to Medi-Cal Programs: A Description of Medi-Cal Programs, Aid Codes, and Eligibility Groups* (December 1999).



There are currently 165 categories or "aid codes" under which an individual or family may be considered eligible.

Medi-Cal Enrollment

The Application Process

County governments play a central role in the Medi-Cal program, particularly in the application and enrollment processes. County workers use state-established criteria to determine Medi-Cal eligibility, and until recently, these workers enrolled most Medi-Cal beneficiaries through a face-to-face interview at the county welfare office. In 1998, the state developed a mail-in application for children and pregnant women, and now the state is creating a mail-in application for adults. Recently, California tested and began implementation of an Internet-based enrollment application, called Health-e-App. The Social Security Administration continues to automatically enroll in Medi-Cal those who receive SSI/SSP.

In-Person Enrollment

To enroll in Medi-Cal in person, prospective enrollees visit the county social services office or meet with an eligibility worker who is "outstationed" at a clinic or community-based organization. An eligibility worker helps in completing the forms and collects necessary documentation (such as proof of household address and income). Eligibility staff conduct verification of income and wages by cross-referencing application data with state databases. Applicants are notified of their status (enrolled or declined) by mail within 45 days of application. The illustration below shows the basic application process, but the process may vary slightly based on each county's procedures.

In-Person Application Process: Basic Steps

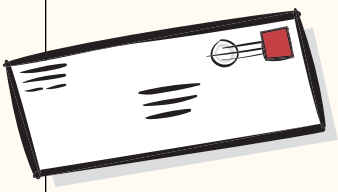
1.

- Applicant meets with county eligibility worker.
- Applicant completes forms and provides documentation (including proof of income, identification, and other documents).
- After an initial screening, applicant may need to schedule an appointment to complete forms.

2.

- County and state workers conduct income and eligibility verifications by using statewide databases.
- Applicant may need to return to office to provide additional documentation or to complete additional forms.
- Applicant may need to provide additional information or documentation following verifications.

3.



- County must notify applicant of acceptance or denial by mail within 45 days of applicant's first visit.

Mail-In Enrollment

Since the implementation of the Healthy Families Program in 1998, children and pregnant women have been able to apply for Medi-Cal by using a mail-in application developed for the use of both programs. Many community organizations have staff, called Certified Application Assistants (CAAs), to help applicants complete the form. The majority of applications (62 percent) are completed with assistance.[19] CAAs receive a $50 payment from the state for each application that results in the successful enrollment of a child in either Medi-Cal or Healthy Families.

The development of a simplified mail-in application for all beneficiaries was required by legislation passed in 2000. Although such application development is still underway, applicants may still mail in the existing forms if they can complete them without assistance.

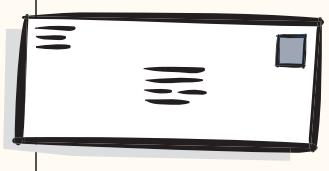
Health-e-App

The State of California recently launched a new way for applicants to sign up for Medi-Cal or Healthy Families by using the Internet. Health-e-App, a Web-based application, streamlines the eligibility determination and enrollment process by reducing paperwork, automating computations such as income, and immediately alerting users to errors prior to submission. Health-e-App also provides real-time preliminary eligibility determination and immediate confirmation of application receipt, thereby improving customer satisfaction. The first of its kind in the country, Health-e-App was developed by the California HealthCare Foundation and the Medi-Cal Policy Institute in partnership with the California Health and Human Services Agency. Statewide implementation began in 2001. For further information about Health-e-App, visit the Web site (http://www.healtheapp.org).

To remain enrolled in Medi-Cal, beneficiaries must recertify annually. In addition, adults are required to report changes in income, marital status, or other status changes to the county social services department within 10 days of a change. Children are continuously enrolled for a 12-month period regardless of changes in income.

Mail-In Enrollment Process (Joint Medi-Cal and Healthy Families Application): Basic Steps

1.

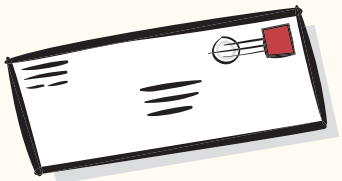


- Applicant completes the mail-in application.
- Applicant may receive help completing the application from a Certified Application Assistant (CAA).

2.

- Application is mailed to the Single Point-of-Entry in Sacramento where it is screened for Medi-Cal or Healthy Families eligibility.
- Healthy Families applications are sent electronically to the HFP enrollment vendor; Medi-Cal applications are mailed to the appropriate county for processing.

3.



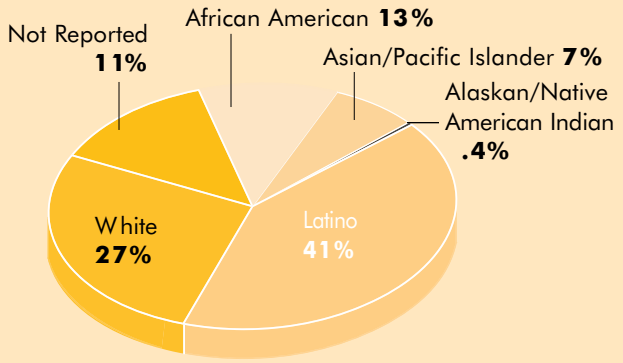
- Applicant is notified by mail of final eligibility. HFP notifies families within ten days of receipt of application; counties have 45 days to process a Medi-Cal application.

Who Is Enrolled in Medi-Cal?

To understand the Medi-Cal program, it is important to know the difference between who is eligible for Medi-Cal and who is enrolled in Medi-Cal. Many individuals meet the eligibility criteria (are eligible) but are not signed up for (enrolled in) Medi-Cal. In 1999, more than 1 million individuals—726,000 children and 685,000 nonelderly adults—likely were eligible for Medi-Cal but not enrolled in the program.[20]

FIGURE 3

Medi-Cal Recipients by Race/Ethnicity



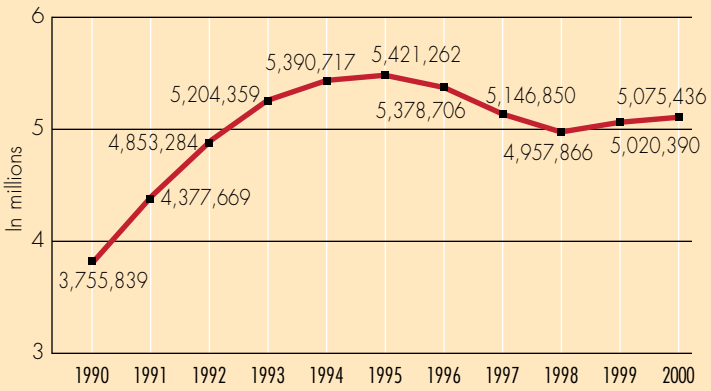
Source: California Department of Health Services, Medi-Cal Eligibility Profiles by County, October 2000.

For each month in 2000, an average number of 5,075,436 children and adults were enrolled in Medi-Cal. More than half (53 percent) of these beneficiaries are children.[21]

Many of the state's elderly and disabled residents are also eligible for Medicare. These "dual eligibles" compose almost 16 percent of Medi-Cal beneficiaries.[22]

FIGURE 4

Medi-Cal Enrollment, CYs 1990–2000
Estimated Average Monthly Eligibles



Sources: California Department of Health Services. *California's Medical Assistance Program: Annual Statistical Report Calendar Year 1999* Table 28. California Department of Health Services. *Counts of Medi-Cal Beneficiaries by County, Pivot Table*. April 2001 (http://www.dhs.ca.gov/mcss).

No single ethnic group represents a majority of beneficiaries, and this diversity presents challenges for the program. While most recipients are born in the United States, many need assistance in languages other than English.

Trends in Medi-Cal Enrollment

Medi-Cal enrollment has grown significantly in the past decade. Enrollment growth in the early 1990s is generally attributed to eligibility expansions adopted in the late 1980s as well as to California's poor economic environment at the time. Enrollment began to decline in 1995, precipitated by changes to the state's welfare program, an improved economy, and immigrants' concerns regarding the impact of Medi-Cal receipt on immigration status issues.

Most recently, it appears that Medi-Cal enrollment may be increasing incrementally. Medi-Cal caseloads for 2001 and 2002 are projected to increase due to the implementation of welfare changes (Section 1931[b] Medi-Cal) and efforts to simplify the program, such as the implementation of continuous eligibility for children.

For more information, read *Medi-Cal County Data Book* (July 1999).

Which Services Are Covered by Medi-Cal?

Required Services

Federal Medicaid law requires states to provide a core set of services, including doctor visits, hospital inpatient and outpatient care, nursing home care, laboratory tests, and x-rays. Additionally, federal requirements under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program mandate Medi-Cal coverage of examinations and follow-up care for children under age 21. California's EPSDT program is known as the Child Health and Disability Prevention (CHDP) program.

Optional Services

Under Medicaid law, states are allowed to offer an additional 34 categories of services in their Medicaid programs and to qualify for federal financial participation. The amount, duration, and scope of services provided within these additional categories vary from state to state. In its Medi-Cal benefits package, California includes 32 of the optional categories, including dental and vision care for adults, as well as prescription drugs.

Limitations

To qualify for federal matching funds, services offered by one category of a state's Medicaid program must be included in the benefits package offered to all beneficiaries. Some states are experimenting with narrowing the benefits packages for newly covered beneficiaries. Federal waivers—exemptions from sections of Medicaid law—are required for such programs.

California includes some Medi-Cal services in its benefits package that do not qualify for federal funds. Services for recent legal immigrants are covered entirely by state funds only, for example. In addition, undocumented individuals who meet Medi-Cal's standard eligibility criteria receive a limited set of benefits—including emergency care, long-term care, and pregnancy-related services—that are covered by state-only funds.

Many services, prescription drugs, and medical equipment must be approved by the state in advance of delivery and must be deemed medically necessary to be covered by Medi-Cal. This prior authorization is referred to as the Treatment Authorization Request (TAR) process.

California includes some Medi-Cal services in its benefits package that do not qualify for federal funds.

How Is Care Delivered?

Medi-Cal services are delivered by a wide array of providers through either a fee-for-service or managed care system.

Providers of Medi-Cal Services

Medi-Cal services are delivered by a wide array of providers through either a fee-for-service (FFS) or managed care system. Providers include county hospitals and health systems, district and private hospitals, academic medical centers, community clinics, nursing homes, physicians, psychologists, dentists, and a broad spectrum of home and community-based providers. Just as the needs of each community are unique, the mix and availability of providers and services vary across the state.

Providers must apply to the state to become authorized as Medi-Cal providers and to receive a Medi-Cal provider number for reimbursement under FFS. Providers working in a managed care environment must have a contract with a Medi-Cal health plan to serve Medi-Cal managed care enrollees.

Dental Care

An estimated 2 million Medi-Cal beneficiaries used dental services of some kind in 1997. Most beneficiaries (90 percent) were eligible for dental services through the fee-for-service system. Delta Dental Plan of California (Delta) has served as the fiscal intermediary for the dental program since 1974. Delta contracts with providers, authorizes treatments, and processes claims.

For some beneficiaries in Los Angeles, Riverside, and San Bernardino, dental care is provided through a managed care dental plan. Beneficiaries in Sacramento County access dental services through one of four dental plans that participate in the GMC model.

For more information, read *Medi-Cal Facts #6: Medi-Cal and Dental Health Services* (January 1999).

Fee-for-Service

Traditionally, Medi-Cal services were provided to most beneficiaries in a fee-for-service (FFS) setting. Today, half of all Medi-Cal beneficiaries receive services in the FFS system. Under this system, a beneficiary finds a certified Medi-Cal physician to deliver care. That physician submits claims for reimbursement after each service or visit. FFS beneficiaries either reside in counties without Medi-Cal managed care, or they are enrolled in an aid code category that is exempt from managed care (this generally applies to elderly and disabled beneficiaries).

Medi-Cal directly reimburses providers under the FFS system. The federal government provides some general guidelines on payments to physicians and providers, but California generally has broad discretion in determining the payment methodology and amount paid for each service.

In 1999, almost 24,000 physicians or physician groups received FFS payments for Medi-Cal services; some 8,767 dentists and 6,011 pharmacists received FFS payments.[23] As for institutional care, some 2,248 long-term care facilities received FFS payments.[24] The number of providers receiving payment, however, is not a good measure of the availability of providers. Policymakers, provider associations, and consumer groups continue to raise concerns regarding adequate access to providers—particularly specialists—in both FFS and managed care.

Managed Care

In 23 counties, the Medi-Cal delivery system has shifted from FFS to managed care to serve most health care needs of Medi-Cal beneficiaries.[25] Four counties have Medi-Cal managed care dental programs, and all 58 counties have Medi-Cal managed care programs for mental health services.[26] Approximately 2.6 million beneficiaries (50 percent) were enrolled in a physical health managed care plan as of October 2000.[27] The majority of these enrollees are children and families.

Although a small number of Medi-Cal recipients have been enrolled in managed care since the 1970s, large segments of the Medi-Cal population began to transition to managed care in the 1990s. At that time DHS issued a strategic plan detailing a series of new and expanded managed care models to be developed in selected counties throughout the state. These models are: Two-Plan Model; Geographic Managed Care; and County Organized Health Systems.

The process of enrollment in a managed care plan occurs independently from enrollment in the Medi-Cal program. Residents of a COHS county, however, are automatically enrolled in managed care. Beneficiaries receive information from the state's contractor for the Health Care Options (HCO) program to help them select a managed care plan. If a Medi-Cal beneficiary fails to select a plan within 30 days, the beneficiary is assigned to a plan.

Mental Health Services

In the late 1990s, Medi-Cal's mental health care system shifted to a managed care delivery approach. Mental health services are now delivered through a system—or set of county systems—distinct from other Medi-Cal services. Counties provide mental health services to Medi-Cal beneficiaries through a publicly or privately operated mental health managed care plan that contracts with the state Department of Mental Health. Each plan is responsible for inpatient and outpatient mental health specialty care for Medi-Cal beneficiaries who meet specific impairment criteria. While all beneficiaries are covered for mental health services, fewer than 6 percent of beneficiaries actually use these services.

For more information, read *Medi-Cal Facts #10: Mental Health Services in Medi-Cal* (April 2001).

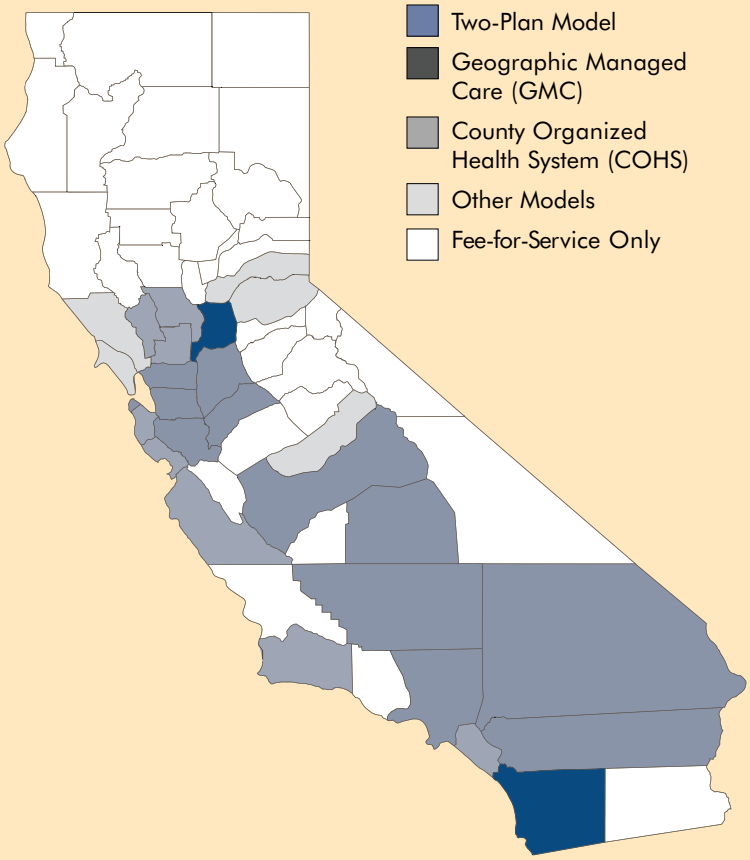
Managed Care Models

Two-Plan Model. CalWORKs-linked Medi-Cal beneficiaries are enrolled in one of two managed care plans on a mandatory basis. Other categories of beneficiaries may be enrolled voluntarily. One plan must be a public entity (known as a "local initiative"); the other must be an HMO (or "commercial plan"). The 12 Two-Plan counties throughout California are among the largest in the state and were selected because of the size of their Medi-Cal populations and their local managed care markets. Approximately 35 percent of all Medi-Cal beneficiaries are enrolled in a health plan within the Two-Plan Model.[28]

Geographic Managed Care (GMC). A model under which the state contracts with a number of commercial managed care plans in a specific geographic region and pays for services on a capitated basis. Beneficiary enrollment in a plan is mandatory for the CalWORKs population. Other categories of Medi-Cal beneficiaries may voluntarily join these plans. The first GMC system was implemented in Sacramento in 1994. A second GMC system began operation in San Diego County in October 1998. Statewide, approximately 6 percent of Medi-Cal beneficiaries are enrolled in a health plan within the GMC model.[29]

FIGURE 5

Medi-Cal Managed Care by County



County Organized Health System (COHS). A managed care model, established in 1982, under which enrollment in a county-run plan is mandatory for the Medi-Cal population and is concurrent with Medi-Cal enrollment. Counties negotiate contracts with the California Medical Assistance Commission (CMAC) and are paid on a capitated basis. Five COHSs provide services in eight counties. Although additional counties have expressed interest in developing this model, changes in federal law are required to expand the number of COHSs in California. The law has set an enrollment cap in COHSs at 10 percent of Medi-Cal beneficiaries statewide. Almost 8 percent of Medi-Cal beneficiaries are currently enrolled in a COHS.[30]

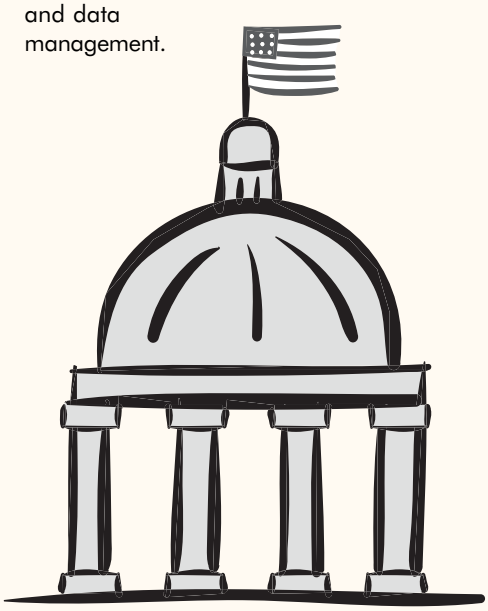
Other Models. A few other types of managed care organizations serve Medi-Cal beneficiaries. They include prepaid health plans (PHPs), primary care case management systems (PCCM), and plans designated as special projects. Less than one percent of Medi-Cal beneficiaries are enrolled in one of these other models.

For more information, read *Medi-Cal Facts #8: Medi-Cal Managed Care* (March 2000).

How Is Medi-Cal Administered?

Administration and regulation of the Medi-Cal program occur at many levels of government and involve federal, state, and county agencies, all of which play a significant role.

Level	Agency	Role
Federal	U.S. Department of Health and Human Services	
	Centers for Medicare and Medicaid Services (CMS, formerly HCFA)	Provides regulatory oversight of Medi-Cal; for example, reviews state plan, and approves and monitors waivers.
State	California Health and Human Services Agency	
	Department of Health Services, Medical Care Services Division	Directly administers Medi-Cal; contracts with vendors for fiscal services, dental care, managed care outreach and enrollment, and data management.
	Other state agencies that receive Medi-Cal funds and administer parts of the program: • California Medical Assistance Commission • Department of Aging • Department of Alcohol and Drug Programs • Department of Developmental Services • Department of Mental Health • Department of Social Services • Managed Risk Medical Insurance Board	
County	Board of Supervisors	
	County Health and Welfare Department	Conducts eligibility determination, enrollment, and recertification; implements state policy changes; and outstations eligibility workers in community sites.



Medi-Cal Financing and Expenditures

Financing

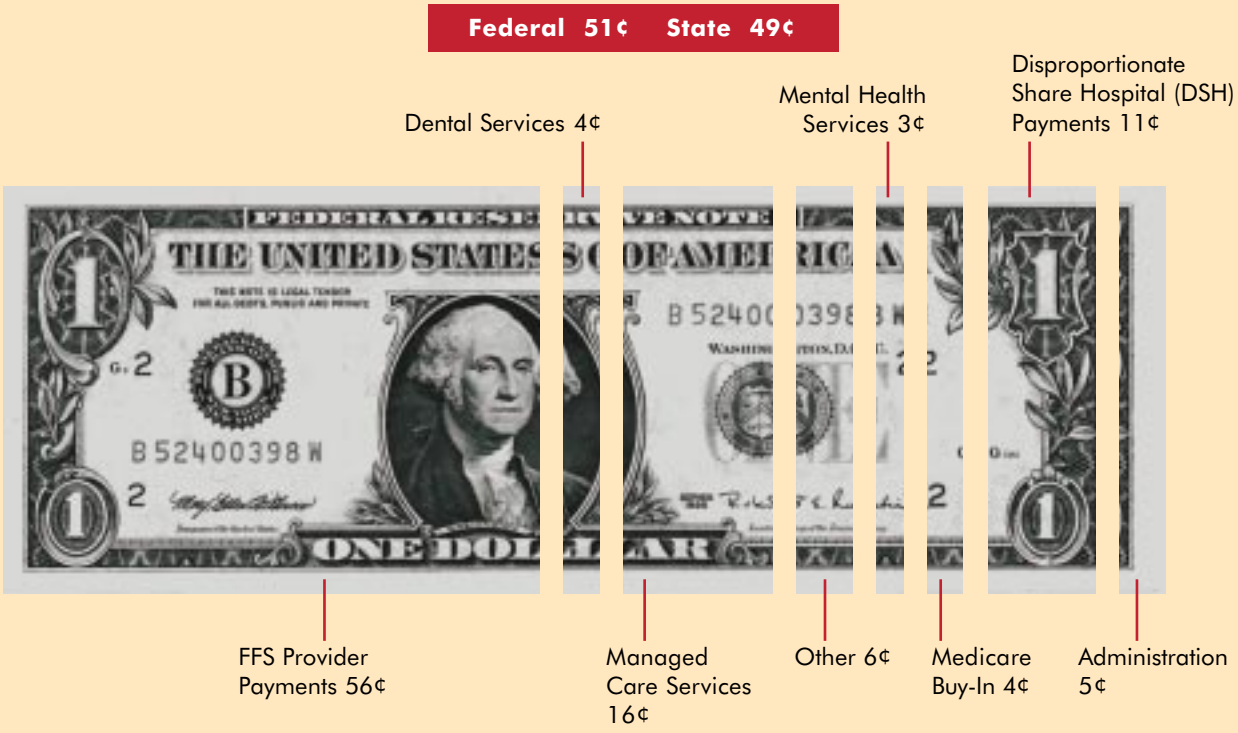
The principal funding sources for Medi-Cal are (1) California General Fund revenues, and (2) matching federal funds derived from what is known as the Federal Medical Assistance Percentage (FMAP). States like California that have a high per capita income level pay a larger share of Medicaid costs than do many other states. In FY 2001–02, the federal government's share of Medi-Cal funds is 51.4 percent.[31]

The governor's May revision of the budget for FY 2001–02 projects Medi-Cal spending to be $26.5 billion in state and federal funds. Approximately $9.7 billion in funds is projected to come from State General Fund revenues, and a proposed $167 million is expected from the Tobacco Settlement Fund; the remainder will come from federal funds and California's DSH program.[32]

Medi-Cal expenditures are roughly 40 percent of the California Health and Human Services Agency budget. While the majority of Medi-Cal funds are within the budget of the Department of Health Services, more than $3 billion is carried in other state department budgets such as the Department of Social Services and the Department of Developmental Services.[33]

FIGURE 6

Follow the Money: The Flow of the Medi-Cal Dollar (FY 1998–99)*



Source: California Department of Health Services. *California's Medical Assistance Program: Annual Statistical Report Calendar Year 1999*. Table 12.
*Total exceeds $1 due to rounding.

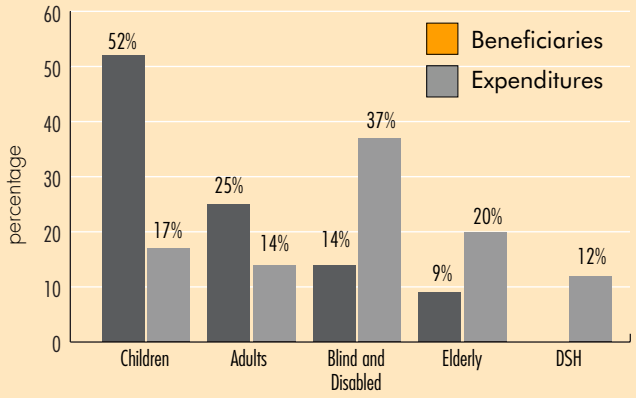
Expenditures

Spending for the Medi-Cal program has more than doubled in the past decade, increasing from $11.9 billion in FY 1992 to $24.1 billion in FY 2001.[34] While the Medi-Cal caseload increased during this time, this does not fully account for growth in spending. One reason is the state's efforts to maximize federal funds under the DSH program (discussed in more detail below). Other reasons include rising health care costs (particularly for prescription drugs and medical equipment) and provider rate increases.

Expenditures per enrollee (including DSH payments and other administrative costs) have increased by 56 percent since 1992. In federal FY 1997–98, California spent, on average, $2,693 per beneficiary. This was significantly lower than the nationwide average of $3,895.[35]

FIGURE 7

Distribution of Medi-Cal Beneficiaries and Expenditures by Group, 1997



Source: Kaiser Commission on the Future of Medicaid and the Uninsured. *Medicaid: A Primer*. August 1999.

While the majority (57 percent) of Medi-Cal expenditures are for elderly, blind, and disabled beneficiaries, these beneficiaries compose only 23 percent of the total Medi-Cal population.

Disproportionate Share Hospitals

The Disproportionate Share Hospital (DSH) program provides federal and state funds to subsidize hospitals that treat large numbers of indigent patients. DSH payments are determined by the proportion of Medi-Cal, low-income, and uninsured persons served by the hospital. Funded by Medi-Cal, the DSH program provides approximately $2 billion of federal and state funds to California's hospitals each year.

Spending for the Medi-Cal program has more than doubled in the past decade.

California's federal allotment of DSH dollars is one of the highest in the country. Counties and other public entities supply the state share of DSH funding through intergovernmental transfers, which are used as the basis for the federal match. The state retains a portion of the funds as an "administrative fee," which then goes into the General Fund. The state redistributes the remaining DSH funds as supplemental payments to both public and private hospitals based on the percentage of Medi-Cal and indigent care provided during the previous year.

Policymakers' concerns over the rapid growth and distribution of DSH funds led Congress to make several changes to the DSH program in the past decade. The Balanced Budget Act of 1997 placed a cap on payment increases, and the Beneficiary Improvement and Protection Act of 2000 made certain adjustments to the caps. As a result, California will see a decline in federal DSH funds beginning in FY 2003.

What Policy Issues Lie Ahead?

Changes to Medi-Cal impact California's entire health care system.

There are significant opportunities to improve the Medi-Cal program. Enrollment and retention problems, outdated processes and procedures, and concerns about beneficiaries' access to high-quality services all require attention on the part of policymakers. Changes to Medi-Cal, however, impact California's entire health care system. Through careful monitoring of major policy changes, unintentional consequences should be anticipated and avoided.

Any discussion of Medi-Cal's future should include examination of these issues:

Simplifying Medi-Cal. A complicated application and enrollment process detracts from administrative efficiency and makes navigation of the program difficult for beneficiaries. The lack of focus on the beneficiary as a customer has a negative impact on enrollment and retention.

Expanding Medi-Cal to Cover Families. Uninsured parents of children enrolled in Medi-Cal could qualify for the Medi-Cal program if some limited changes were made to the eligibility criteria. In adding these parents, the program should aim for simplicity in its new eligibility criteria.

Ensuring Access to Services. Many beneficiaries are having difficulty finding physicians and other providers near them who are willing to accept new Medi-Cal patients. One barrier to access may be California's low Medi-Cal payment rates, which may discourage many providers from fully participating in the program. Before further rate increases are passed, it is reasonable for policymakers to expect to be able to understand the nature and extent of access problems, and whether and how increasing provider payment rates would improve access.

Improving Quality. Information about the quality of care provided to Medi-Cal beneficiaries is essential to measuring and improving program performance. Unfortunately, very little standardized data on quality of care is available for either the Medi-Cal managed care or fee-for-service programs.

Meeting Consumer Needs. The state's growing population of elderly and disabled consumers is increasing demand for long-term care provided in less-restrictive home and community-based settings. Other demographic changes, such as the increasing number of beneficiaries for whom English is a second language, also need attention to guarantee that Medi-Cal providers can meet and address the needs of a linguistically and culturally diverse population.

Improving State-County Processes and Communication. Program efficiency is key to controlling Medi-Cal costs as well as ensuring its effectiveness. Implementation of efforts to improve and streamline the Medi-Cal program are often delayed by the layers of complexity and poor communication between the state and its 58 counties.

Information about the quality of care provided to Medi-Cal beneficiaries is essential to measuring and improving program performance.

Online Resources

National Sites

- **Agency for Healthcare Research and Quality**—www.ahrq.gov
- **Center for Health Care Strategies**—www.chcs.org
- **Center on Budget and Policy Priorities**—www.cbpp.org
- **Centers for Medicare and Medicaid Services (CMS),** formerly the Health Care Financing Administration (HCFA)—www.hcfa.gov
- **Kaiser Commission on Medicaid and the Uninsured**—www.kff.org/kcmu
- **Medicaid Clearinghouse of Families USA**—www.familiesusa.org/html/medicaid/medicaid.htm
- **National Association of State Medicaid Directors**—http://medicaid.aphsa.org
- **National Center for Health Statistics**—www.cdc.gov/nchs
- **The Urban Institute**—www.urban.org

State Sites

- **California Budget Project**—www.cbp.org
- **California Department of Health Services (DHS)**—www.dhs.cahwnet.gov
- **California Health and Human Services Agency**—www.chhs.cahwnet.gov
- **California Healthline**—www.californiahealthline.org
- **Health-e-App**—www.healtheapp.org
- **Healthy Families Program**—www.healthyfamilies.ca.gov
- **Legislative Analyst's Office**—www.lao.ca.gov
- **Senate Office of Research**—www.sen.ca.gov/sor

Glossary

Access for Infants and Mothers (AIM)—The AIM program, administered by the state of California, provides health care coverage to pregnant women and their infants with incomes between 200 and 300 percent of the Federal Poverty Level. Services include prenatal visits, hospital delivery, and full health services to newborn children through two years of age.

Aid to Families with Dependent Children (AFDC)—AFDC was the welfare entitlement program in effect prior to 1996 welfare reform. AFDC provided cash aid; its importance is still reflected in the Medically Needy program, which has retained eligibility rules based on AFDC. The 1931(b) program has retained some (but not all) AFDC rules. CalWORKs is the new California welfare-to-work program for families with minor children at home.

Assistance Unit—A group of people receiving benefits together. For Medi-Cal, this is usually a family unit or subset of a family unit. For cash, Medi-Cal, and Food Stamps, assistance units may be determined differently. For CalWORKs and Medi-Cal, the assistance units consist of people who have a legal responsibility to one another: parents, children, and spouses. Determining who is in an assistance unit can be quite complicated and has a significant impact on whether or not a person will qualify for Medi-Cal.

California Children Services (CCS)—The CCS program, administered by the state and counties, provides funding for medical care of eligible low-income families with children who have serious medical problems, such as acute injury and illness, genetic diseases, chronic conditions or physical disabilities, congenital defects, and major injuries due to violence and accidents. CCS covers medical services, including physician services, hospital care, laboratory work, x-rays, rehabilitation services, pharmaceuticals, equipment, and case management.

CalWORKs (California Work Opportunity and Responsibility to Kids)—CalWORKs is California's welfare-to-work program established by the state Welfare to Work Act of 1997. The program, which replaced the Aid to Families with Dependent Children program (AFDC), makes welfare a temporary source of assistance by putting a five-year lifetime limit on receipt of benefits.

Capitation—A method of payment in managed care in which a provider is prepaid a fixed amount per person enrolled in an individual plan. This fee is based on a defined set of benefits and is typically paid monthly regardless of the type of care delivered or the frequency with which a patient uses services.

Categorically Needy—Specified groups of individuals who, based on stipulated income criteria, are eligible automatically for Medi-Cal coverage. Categorically needy groups include families with children, pregnant women, elderly, blind, and disabled individuals.

Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration or HCFA)—A federal agency within the U.S. Department of Health and Human Services, CMS runs the Medicare and Medicaid programs; together with the Health Resources and Services Administration, it also runs the State Children's Health Insurance Program (SCHIP). Healthy Families is California's SCHIP program.

Child Health and Disability Prevention (CHDP)—CHDP, administered by the state and counties, provides preventive health screening examinations to children with family incomes of less than 200 percent of the Federal Poverty Level. States are required to provide these services under a federal program called EPSDT (Early and Periodic Screening, Diagnostic, and Treatment).

County Organized Health System (COHS)—A Medi-Cal managed care model in which enrollment in a single county-run plan is mandatory for the Medi-Cal population and occurs concurrent with enrollment in the Medi-Cal program. Counties negotiate their contract with the California Medical Assistance Commission (CMAC) and are paid a set amount per member per month, known as a capitated rate. There are currently five County Organized Health Systems that cover Medi-Cal beneficiaries in eight California counties: Monterey, Napa, Orange, Santa Cruz, San Mateo, Santa Barbara, Solano, and Yolo.

Crowd-Out—The indirect outcome that subsidization of health coverage might cause, according to economic theory. Under crowd-out, an employer or employee drops existing private health insurance coverage to take advantage of publicly subsidized health care coverage. Recent debate regarding Healthy Families and other SCHIP programs has included discussions of whether crowd-out will occur.

Deprivation—Deprivation is a circumstance that must exist in a family for members to be eligible for CalWORKs or AFDC-related Medi-Cal programs. Deprivation exists when one of the following is true: a parent is absent from the home; is incapacitated (unable to work or care for children); is disabled; is deceased; is employed less than 100 hours per month or has net earnings at or below 100 percent of the Federal Poverty Level. The deprivation requirement exists in addition to income and asset limits.

Disproportionate Share Hospitals (DSH)—The Medi-Cal DSH program (also known as SB 855) provides supplemental funding to hospitals that treat large volumes of indigent and very-low-income patients. California uses intergovernmental transfers from public entities to draw down matching federal DSH funds. DSH funds are distributed to public and private hospitals based on their Medi-Cal inpatient days and their revenues from low-income patient utilization.

Dual Eligible—Elderly and/or disabled persons who qualify for benefits under both the Medicaid and Medicare programs are referred to as "dual eligibles." Payments for services for these individuals are covered by Medicare and are made before the Medicaid program makes any payments.

Edwards (Aid Code 38)—Aid Code 38, often referred to as "Edwards," is a temporary holding category where recipients are placed for an average of one to two months when they are discontinued from cash assistance (CalWORKs) and their Medi-Cal eligibility is being redetermined.

Edwards v. Kizer—A court case that assures continuing Medi-Cal coverage for most families leaving CalWORKs for one to two months until their eligibility for any other Medi-Cal program is determined. If the family cannot be located or does not provide the necessary form within 30 days, their Medi-Cal benefits are terminated.

Family PACT (Family Planning, Access, Care and Treatment)—A state-administered family planning program funded by Medi-Cal. Established in 1997, Family PACT provides coverage for family planning services to women and men with incomes at or below 200 percent of the FPL who otherwise are not eligible for Medi-Cal without a share of cost.

Federal Poverty Level (FPL)—The Federal Poverty Guidelines, often referred to as the "Federal Poverty Level," are issued each year in the Federal Register by the Department of Health and Human Services. The guidelines, a simplified version of the poverty thresholds used by the Census Bureau for statistical purposes, are used to determine financial eligibility for certain federal and state programs, including Medi-Cal. As of March 2001, the Federal Poverty Level is $8,590 (annual income) for an individual and $17,650 for a family of four.

Federally Qualified Health Centers (FQHC)—Health clinics, such as community health centers, migrant health centers, and health care services for the homeless, which receive funding under the Public Health Services Act.

Fee-for-Service—The traditional method of paying for care, in which health care providers are reimbursed for a particular service (such as office visits, medical procedures, and prescriptions) at a rate established by the Medi-Cal program. Roughly 50 percent of Medi-Cal beneficiaries in California receive coverage through a fee-for-service system.

Fee-for-Service Managed Care—A Medi-Cal managed care model through which Medi-Cal beneficiaries are assigned a primary care provider for medical case management. The primary care provider acts as a gatekeeper for specialty services. These providers are paid on a fee-for-service basis.

Food Stamps—A federal in-kind benefit program that provides low-income families with vouchers that can be used to purchase food. Medi-Cal eligibility workers are able to determine eligibility for Food Stamps.

Geographic Managed Care (GMC)—A Medi-Cal managed care model under which the state contracts with a number of commercial managed care plans in a specific geographic region and pays for services on a capitated basis. Beneficiary enrollment in a plan is mandatory for the CalWORKs population. Other categories of Medi-Cal beneficiaries may voluntarily join these plans. Currently, there are two GMC systems in California: Sacramento, implemented in 1994, and San Diego, implemented in November 1998.

Health Care Options (HCO)—A program administered by the California Department of Health Services that is responsible for the education of eligible Medi-Cal beneficiaries regarding the Medi-Cal managed care system, enrollment into a specific health plan, and disenrolling from or changing health plans. A state contractor performs HCO activities. Maximus has been the contractor since January 1997.

Health Maintenance Organization (HMO)—A health plan (an organized group of practitioners) that delivers and manages the provision of health services under an agreement that the plan receives a specified rate for each person enrolled in the plan. The HMO is usually paid a monthly premium for each person enrolled in the plan regardless of the frequency or type of service provided.

Healthy Families Program—California's State Children's Health Insurance Program (SCHIP). Healthy Families provides health coverage to children in families with incomes between 100 percent and 250 percent of the Federal Poverty Level who do not qualify for Medi-Cal and do not have private insurance. Services covered are similar to those in the benefits package for California state employees and require payment of a monthly premium. A federal waiver has been submitted by California requesting permission to include parents.

Long-Term Care—Refers to a wide range of services provided to elderly individuals and people with disabilities who need ongoing care due to chronic conditions. Services may include medical care, therapy, rehabilitation, case management, protective supervision, and assistance with "activities of daily living" such as eating, bathing, and toileting.

Managed Care—A method of delivering and financing health care that seeks to control health care costs by coordinating an individual's health care. Managed care plans (sometimes called HMOs) typically receive a prepaid rate for each member enrolled in the plan and maintain some level of risk for providing all necessary services for enrolled members within that prepaid rate.

Managed Risk Medical Insurance Board (MRMIB)—A state entity, governed by a board of five appointed members, that administers three programs, each of which provides some form of health care coverage to specific populations. These programs are AIM, Healthy Families, and Major Risk Medical Insurance Program (MRMIP).

Medicaid—A federal program, established in 1965, that provides health care coverage for low-income families and certain individuals who lack other health insurance. Medi-Cal is the name of California's Medicaid program, which, like other states' programs, is funded by both the federal and state governments.

Medi-Cal—Medi-Cal, California's Medicaid program, provides health care coverage for low-income and disabled individuals who lack health insurance. Jointly funded by the state and federal governments, it is the primary source of health and long-term care coverage for 5.1 million Californians.

Medically Indigent (MI)—The Medically Indigent program provides Medi-Cal coverage for people who have incomes or assets too high to qualify for any other Medi-Cal program (including Medically Needy Medi-Cal), but not high enough to cover the cost of their care. Most MI recipients are children, pregnant women, or nursing facility residents.

Medically Indigent Adult Program (MIA)—MIA is a county medical assistance program in the larger California counties. MIA serves the same population as the County Medical Services Program: people who are not eligible for Medi-Cal but who are also unable to pay for their medical care. MIA programs are funded and administered by the county. MIA is not a Medi-Cal program.

Medically Needy (MN)—California's Medically Needy program extends Medi-Cal eligibility to people who may have too much income to qualify under the categorically needy criteria. The medically needy program allows individuals to deduct medical expenses from their income, thereby reducing it to a level that makes them eligible for Medi-Cal coverage.

Medicare—A federal program, established in 1965, that pays for health care services for U.S. residents who are 65 or older, or who are permanently disabled. There are no income eligibility criteria for the program.

Outstationing—A form of Medi-Cal outreach that allows individuals to apply for Medi-Cal at locations other than those at which applications for cash assistance (CalWORKs) are received and processed. Most common locations for outstationing are perinatal clinics, hospitals, and schools. Additional locations include family support centers, mental health centers, local health departments, and community-based organizations (CBOs). Innovative outstation locations are adult day-care centers, drug rehabilitation facilities, clinics serving people with AIDS and tuberculosis, and probation facilities.

Prepaid Health Plans (PHPs)—In the Medi-Cal program, PHP refers to a Medi-Cal managed care model through which Medi-Cal beneficiaries may voluntarily enroll in a managed care plan. PHPs are required to provide, on a capitated at-risk basis, all basic Medi-Cal covered benefits, excluding long-term care and treatments such as major organ transplants and chronic renal dialysis. PHPs provide case management, prevention, and health maintenance services.

Primary Care Case Management (PCCM)—A Medi-Cal managed care model under which primary care providers formally contract with the DHS to provide primary care and specialty services for Medi-Cal beneficiaries on a capitated basis. Enrollment in PCCM is voluntary for Medi-Cal beneficiaries. PCCM was created as a transitional model to full-risk managed care for Medi-Cal. DHS has limited enrollment in PCCM in areas where other managed care models have been phased in.

Section 1931(b)—A category of Medicaid coverage created as a part of federal welfare reform legislation in 1996. Section 1931(b) covers people receiving cash assistance or those leaving assistance for work.

Sneede—*Sneede v. Kizer* was a 1991 Ninth Circuit Court of Appeals case in which the court ruled that if a family does not meet Medi-Cal eligibility as a whole, the family's eligibility may be determined in smaller units (Mini Budget Units or MBUs) if certain circumstances apply. *Sneede v. Kizer* held that parents are financially responsible for their children, and that spouses are financially responsible for spouses. "Sneeding" is another way to determine eligibility.

Social Security Aged/Social Security Disability (SSA/SSD)—Social Security Aged and Disability insurance benefits are cash payments issued by the Social Security Administration. These benefits do not automatically entitle someone to Medi-Cal. They do, however, establish the necessary "linkage" factor. This means that because the recipient is elderly or disabled, he or she may qualify for Medi-Cal if income and asset limits are met.

Special Projects (SP)—Medi-Cal managed care Special Projects are targeted managed care programs or pilot projects developed by the Department of Health Services to improve health care for identified populations. Currently, Special Projects target elderly beneficiaries and individuals with HIV/AIDS in a limited number of California counties.

Supplemental Security Income (SSI/SSP)—SSI is a cash payment designed to increase the monthly income of the elderly and disabled to a minimum amount deemed necessary to live. The federal government sets a minimum amount for SSI payments, and each state may choose to increase this limit based on cost-of-living adjustments. California has chosen this option and pays an additional amount above the federal limit called the State Supplemental Payment (SSP). Beneficiaries receive both the federal and state payments in one SSI check.

Temporary Assistance for Needy Families (TANF)—The federal welfare program, formerly known as Aid to Families with Dependent Children (AFDC), that provides cash benefits for poor women and their children. CalWORKs is the name of California's TANF program.

Transitional Medi-Cal (TMC)—Created by the Federal Family Support Act in 1988, TMC has been available in California since 1990 to families who are losing their cash assistance due to increased earnings from employment. Families can receive TMC for up to 12 months as long as they had received at least three months of Section 1931(b) Medi-Cal prior to losing Medi-Cal coverage due to increased employment earnings. The second six months of TMC have an earned-income limit. An additional 12 months of coverage also is available under a state-funded program for people 19 years and older with family earned income (minus child care deductions) at or below 185 percent of FPL.

Treatment Authorization Request (TAR)—A process under which Medi-Cal providers are required to file a TAR with DHS to receive prior authorization before providing certain services to beneficiaries.

Two-Plan Model—A Medi-Cal managed care model through which counties designated by the Department of Health Services enroll Medi-Cal beneficiaries into one of two managed care plans on a mandatory basis. One of the plans is intended to be a public entity known as a Local Initiative, and the other plan is an HMO or commercial plan. Some counties have not established a public plan but instead have contracts with two commercial plans. The 12 Two-Plan counties throughout California are among the largest in the state and were selected because of the size of their Medi-Cal populations and their local managed care markets.

Waiver—A term generally used to refer to a release from requirements in particular sections of federal law. If a state wants to make changes to its Medicaid program that are in conflict with federal Medicaid requirements, the Centers for Medicare and Medicaid Services (formerly HCFA) of the U.S. Department of Health and Human Services must approve a waiver from the relevant requirements of the Social Security Act.

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